in the absence of other symptoms. I do not believe that reconstruction of the artery is indicated in the first instance unless the patient is losing weight and a pressure gradient can be shown across the stenosis; there is no other good evidence that the pain is due to ischaemia and reconstructive surgery greatly increases the potential danger of the operation.

My reason for sitting on the fence, as is frequently the case in surgical practice, is based on a patient—the first in whom I saw this condition diagnosed. A 45 year old woman had had a vagotomy for a very small duodenal ulcer and a cholecystectomy for a solitary gall stone, and continued to complain as she awoke from each operation of the same abdominal pain. I had been persuaded to operate on her, and at the first operation I found an epigastric hernia which I repaired, thereby performing a very effective sham procedure. That evening she told me her pain was still present. I eventually decompressed her coeliac axis nine months later. She has remained free of pain for eight years. She had been steadfast in her complaint of pain with no other associated symptoms. One other patient who had a six year history of pain alone appears to be cured. The other two patients whom I have treated were polysymptomatic; they happened to have the anatomical abnormality but did not benefit at all by my operation—and have hung like mill stones round my neck ever since.

C W JAMIESON

Consultant Surgeon,
St Thomas's Hospital,
London SE1 7EH

1 Harjola PT. A rare obstruction of the coeliac artery. *Annales Chirurgiae et Gynaecologiae Fenniae* 1963;**52**:547-9.
2 Anonymous. Compression of coeliac axis [Editorial]. *Br Med J* 1970;i:317.
3 Marable SA, Kaplan MF, Beman FM, Molnar W. Celiac compression syndrome. *Am J Surg* 1966;**115**:97-102.
4 Watson WC, Sadikali F. Celiac axis compression syndrome: experience with twenty patients and a critical appraisal of the syndrome. *Ann Intern Med* 1977;**86**:278-82.
5 Williams S, Gillespie P, Little JM. Celiac axis compression syndrome. Factors predicting a favourable outcome. *Surgery* 1985;**98**:879-86.
6 Stanley JC, Fry WJ. Median arcuate ligament syndrome. *Arch Surg* 1977;**103**:252-60.
7 Szilagyi DE, Rian RI, Elliott JP, Smith RF. The celiac axis compression syndrome: does it exist? *Surgery* 1972;**72**:849-52.
8 Linder HH, Kemprud E. A clinicoanatomical study of the arcuate ligament of the diaphragm. *Arch Surg* 1971;**103**:600-11.
9 Evans WE. Long term evaluation of the celiac band syndrome. *Surgery* 1974;**76**:867-76.
10 Carey JP, Stemmer EA, Connolly JE. Median arcuate ligament syndrome. *Arch Surg* 1963;**99**:441-7.
11 Brandt LJ, Boley SJ. Celiac axis compression; a critical review. *Dig Dis Sci* 1978;**23**:633-43.
12 Watson WC, Williams PB, Duffy G. Epigastric bruits in patients with and without celiac axis compression. A phonoarterio graphic study. *Ann Intern Med* 1973;**79**:211-6.

Paying for old age

Permeating a conference on "The Elderly: Partnership in Care" held last week at the Royal Society of Medicine was an awareness of the demographic tide licking at the ankles of the speakers. In the next 25 years the numbers of people in Britain over the age of 85 will increase by 75%. The presence at the meeting of the Secretary of State, Mr Norman Fowler, and the Chief Medical Officer, Sir Donald Acheson, might be seen as welcome evidence that the DHSS has recognised the urgent need for an effective national policy on the care of the elderly. Such a hope was, however, quickly dispelled by Mr Fowler, who stated quite explicitly that old people who own their houses or have pensions will be able "to purchase the care they need, leaving state help to be concentrated on those who cannot pay for themselves." The government would, he said, facilitate collaboration between the public and private sectors.

Clearly the government is not disturbed by the anger and despair of families who are told that an old person needs residential care, that only the private sector can provide it, and that the DHSS will not pay the fees of someone who owns property or has personal capital. Couples who had hoped to leave their children the family home—often the only capital asset—are now being told that it must be sold to finance care for one or both at a cost of around £10 000 a year. It is one thing for a patient to opt for the private sector; it is quite another for patient and family to be pressured into private care and stripped of their modest assets.

Fortunately this black scenario applies to only a few of even the very old; most old people still live (and die) in their own homes. Many will need some help from community services in their last years; and what emerged from the conference (organised by the Brendoncare Foundation) was the variability of these services from one health district to another. The answer seems to lie (once again) in planning. Each health district should have a planning team with the task of bringing together the many agencies (voluntary, private, and state) providing services for the old. Once the team has full information on the resources available it should be able to coordinate the efforts—bearing in mind the importance of giving the consumer, client, or patient a large voice in deciding what is provided. Almost inevitably prescriptions of this kind are phrased in an amalgam of sociomedical buzz words—but the concepts are nevertheless correct. If half a dozen agencies are trying to help old people in one district and not being coordinated there must be inefficiency.

The conference ended in an atmosphere of optimism; clearly much can be done to improve services for the elderly by improving their organisation. But the tide is continuing to rise; the resources available are not keeping pace; and Sir Ronald Gibson's opening words remain true: "The care of the elderly is still a scandal and the system by means of which these vulnerable citizens are managed—or manipulated—remains a disgrace."